

**New Roles for the Physician's Assistant and
Advanced Practice Registered Nurse
in Michigan**

By:

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New Roles for the Physician’s Assistant and Advanced Practice Registered Nurse in Michigan

By Barbara Bosler and Kathleen A. Reed

Introduction

On March 22, 2017, the practice of physician’s assistants (PAs) changed in Michigan as a result of PA 379 of 2016, which permits a PA to practice without delegation and supervision from a physician or podiatrist, provided there is a signed, compliant practice agreement between the PA and a participating physician or podiatrist. A few weeks later, on April 9, 2017, PA 499 of 2016 designated a new category of specialty-certified registered nurses called the advanced practice registered nurse (APRN), comprised of certified nurse midwives, nurse practitioners (NPs) and clinical nurse specialists. PA 499 further granted APRNs the authority to undertake specified medical tasks independent of physician delegation and supervision, including, most importantly, the authority to prescribe non-controlled substances.

The purpose of this paper is to explore and explain the impact of PA 379 and PA 499 of 2016 on the legal scope of practice of PAs and APRNs in Michigan. Part One of the paper will provide a nation-wide as well as Michigan-specific academic review of PA and NP history and milestones, scope of practice, education, and state and federal legislation impacting these two professions. Part Two will provide an in-depth legal analysis of how these changes to the Michigan Public Health Code impacts PAs and advanced practice providers (APPs) in actual practice.

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Part One
Academic Review
By Barbara Bosler

Physician’s Assistants

History and Milestones

In 2016, the U.S. Bureau of Labor Statistics described PAs as individuals who, “practice medicine on teams with physicians, surgeons, and other healthcare workers.”¹ PA duties are to examine, diagnose and treat patients in physician offices, hospitals, outpatient clinics and almost any healthcare setting.² This means PAs take and review patient medical histories, examine patients, order diagnostic tests, give treatment, prescribe medicine, assess and record patient progress, educate and counsel patients and their families, participate in preventative care outreach programs, and perform research to keep abreast of the latest treatments.³

The U.S. Bureau of Labor Statistics predicts that the PA job market will grow 37% from 2016 to 2026 because of the increased aging population in the United States.⁴ Baby boomers will require more health care and the numbers of patients with chronic diseases will increase healthcare demand.⁵ This prediction for the PA profession far exceeds that of other professions because of this increased healthcare demand.⁶ Additionally, PAs are trained more quickly than physicians and can provide many of the same services as physicians.⁷

In 2016, PAs held about 106,200 jobs in the United States with the top employers being Physician Offices (56%), Hospitals (23%), Outpatient Care Centers (8%), Educational Services (3%) and Employment Services (3%). The median wage was \$101,480, with the lowest 10% earning less than \$65,620 and the highest 10% earning more than \$142,210.⁸

In 2017, the American Academy of PAs (AAPA) reported that there were over 123,000 practicing PAs in the United States; 4,750+ in Michigan.⁹ The top medical specialties and patient settings that Michigan PAs practice are surgery, family medicine, and internal medicine in physician offices and hospital settings.¹⁰

PAs are invaluable because they are trained using the same medical model as physicians.¹¹ This means the curriculum for PA students includes similar courses as medical students and the courses are designed to include classroom and clinical practice training.¹² At the completion of their curriculum, PA students take a general medicine exam to become licensed and certified to practice.¹³ As experts in general medicine, PAs learn to make life saving diagnostic and therapeutic decisions while working collaboratively with all other health care providers.¹⁴ Like physicians, PAs are required to complete continuing medical education throughout their careers, allowing them to specialize in other medical areas.¹⁵

Consistent with U.S. Bureau of Labor job market projections, AAPA supports that the demand for PAs has increased.¹⁶ PA ability and training is thought to have significantly reduced hospital

readmission rates, decreased inpatient lengths of stay and decreased infection rates.¹⁷ A 2014 Harris poll reported that 93% of patients treated by PAs value them as trusted providers; 92% believe it is easier to get a medical appointment with a PA, and 91% believe that PAs improve overall quality of care.¹⁸

A review of history shows how the PA profession achieved this recognition. Dr. Eugene A. Stead, Jr., MD at Duke University Medical Center, created the first class of PAs in 1965.¹⁹ The Vietnam War was still active and there was a shortage of primary care physicians.²⁰ Dr. Stead chose four Navy Hospital Corpsmen who had received considerable medical training during their military service to design the PA curriculum blueprint at Duke.²¹ In 1967, the first PA class graduated.²²

The PA concept gained early recognition and acceptance for creatively addressing how to provide patient care in spite of the physician shortages. The medical model for training PAs was used, which involved following disease pathophysiology in diagnosing and treating patients.²³ Medical communities came together to identify faculty and internship sites. Preliminary accreditation standards were identified and the national certification framework for recognizing academic organizations and individual student achievement was quickly developed.²⁴

The AAPA fully detailed the historical milestones of the PA profession.²⁵ The highlights are:

In 1961, the idea of a physician's assistant began with a proposal for an advanced medical assistant to serve as an intermediate between a technician and doctor, who could assume some medical responsibility.

In 1968, the American Association of Physician Assistants, now known as American Academy of PAs, was incorporated. Recognition of this Association and the PA profession resulted in establishing a national office in Washington, D.C. in 1973.

In 1971, Congress passed the Comprehensive Health Manpower Training Act, which approved \$4 million to establish new PA educational programs across the country. Rudimentary standards for PA program accreditation were endorsed and the American Medical Association formally recognized the PA profession to further solidify national certification requirements and practice characteristics.

In 1976, the Committee on Allied Health Education and Accreditation (CAHEA) was established as an independent organization to accredit allied health education programs, including PA programs. This Committee was replaced by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) in 1994, which the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) was a member. In 2001, ARC-PA withdrew from CAAHEP, and became the independent accrediting body for all physician assistant programs across the United States.

In 1980, there were 6,975 AAPA members and physician assistants had prescriptive authority in 10 states.

In 1986, AAPA succeeded in obtaining Medicare coverage of PA services when assisting in surgery, and for services provided in hospitals and nursing homes. In 1987, Medicare coverage expanded to include outpatient services provided by PAs in rural, underserved areas approved by Congress.

In 1990, PA prescriptive authority was allowed in 30 states and the District of Columbia. AAPA membership was up to 14,387.

In 1992 and 1993, PAs were commissioned as officers in the U.S. Army and U.S. Coast Guard, and the AAPA was granted observer status in the House of Delegates. There were more than 23,000 practicing PAs throughout the United States and 57 accredited PA education programs. In 1997, the Health Care Services Committee was established to coordinate legislative and regulatory efforts to eliminate practice barriers and encourage the utilization of physician and PA teams.

In 1998, there were 41,000 PA graduates, 110 accredited PA programs, and 44 states, plus DC and Guam, which allowed prescriptive privileges to PAs.

In 2000, legislation was passed to authorize PA practice in all 50 states. Legislative work also began to recognize the PA profession internationally.

In 2001, the AAPA convinced the American Medical Association (AMA) to revise language in its coding book for purposes of medical service reimbursement to be applied to non-physician and physician health care providers. Additionally, the Joint Commission on Accreditation of Health Care Organization Board of Commissioners approved the appointment of AAPA to the JCAHO Standards Oversight Committee, which impacted the monitoring and development of quality of care standards throughout all healthcare facility types. There were now 40,469 practicing PA graduates, 129 accredited PA programs and 47 states plus DC and Guam, which allowed PA prescriptive privileges.

In 2003 and 2004, the Centers for Medicare and Medicaid Services allowed PAs to have an ownership interest in a practice under the Medicare program, and Blue Cross Blue Shield included PAs as covered professional providers in its BCBS Federal Employees Health Benefit Program.

In 2008, AAPA established PAs for a Healthy America to advocate its position on health care issues during the 2008 presidential election. The AAPA also worked with Congress to establish a Director of PA Services within the Office of the Under Secretary of Veterans Affairs for Health at the Veterans Health Administration.

In 2010, The Affordable Care Act contributed greatly towards recognizing PAs. For the first time, PAs were acknowledged as a primary care provider along with Nurse Practitioners (NPs) and physicians. PAs were empowered to lead patient centered medical teams and to practice autonomously or collaboratively based on state law with other healthcare team members.

There were now 148 accredited PA programs and all 50 states, DC, and Guam recognized the prescriptive authority of practicing PAs.

Scope of Practice

Integral to the PA profession's history is the evolution of this profession's scope of practice. In general, scope of practice is defined as the extent that providers may render healthcare independently. This is ultimately determined by the education standards of the profession and the dictates of statutes, administrative rules, and case law.²⁶ The Centers for Medicare and Medicaid Services (CMS) and other insurers have also asserted a role in defining scope of practice by what services they will reimburse for each healthcare professional.²⁷

Indicators used to describe this scope are whether: a) physician supervision is required; b) there are supervision/collaboration barriers to overcome; c) scope is determined at the practice site; d) there are non-physician-to-physician supervision ratios; e) prescription authority is allowed and to what extent; and f) non-physician documentation requires a co-signature by the supervising or participating physician.²⁸

Prior to the 2017 changes to the Public Health Code, Michigan PAs were granted statutory authority to provide medical care services under the supervision of a physician, so long as those services fell within the scope of practice of the supervising physician.²⁹ Services like examining patients, ordering diagnostic tests, and prescribing therapy were all acceptable activities for PAs, so long as their supervising physician was allowed to perform those services. The exception to this was that PAs could not independently perform invasive procedures; however, PA's could assist the supervising physician in performing these procedures.³⁰

Michigan prescribing authority allowed physicians to delegate to the PA authority to prescribe Schedule III to V controlled substances if certain conditions were met.³¹ (These substances are drugs with little potential for abuse and have accepted medical uses.) These conditions were:³²

- The presence of a written authorization containing the signatures and license number of the PA supervising physician at each site of practice;
- Any limitations or exceptions to the delegation included in the written authorization;
- The presence of an effective date; and
- Evidence that the authorization was reviewed and updated annually.

Prescribing authority for Schedule II controlled substances, however, could only be delegated if the practice site for both the physician and PA was a hospital, freestanding surgical outpatient facility, or hospice. Further, prescriptions for patients being discharged could not be issued for more than a seven-day period. The limited authority for these substances is because even though they are drugs with an accepted medical use, they have a high potential for abuse.³³

The MPHC also defined parameters for the supervising physician. A sole practitioner supervising physician could not supervise more than four PAs at a time and not more than two PAs could

perform services at a site other than where the physician practiced.³⁴ However, a physician employed by, or with privileges at, a licensed health facility could supervise more than four PAs at the facility. Lastly, supervising physicians were responsible for verifying PA credentials, monitoring the medical care services provided and evaluating performance.³⁵

With the 2017 MPHC changes in Michigan, and similar changes made to state law in other states, the scope of practice changed for PAs. The American Medical Association (AMA) published a 2018 advocacy brief outlining these changes and its position on the current state of PA scope of practice.³⁶ The national results from surveying the U.S. are:

*Requirements for collaborative or supervisory arrangement*³⁷

- In 47 states, PAs are supervised by physicians.
- In two states, PAs are subject to collaborative agreements with physicians (AK, IL)
- In two states, alternate arrangements are allowed:
 - New Mexico calls for supervision for PAs with less than three years of clinical experience, and for specialty care PAs, and
 - Michigan requires PAs to work under a participating physician with a participating agreement in place.

*Regulation*³⁸

In 43 states, PAs are regulated by the medical board. However, in 8 states (AZ, CA, IA, MA, MI, RI, TN, UT), PAs have a separate and independent regulatory board.

*Scope of practice determination*³⁹

In 47 states, PA scope of practice is determined with the supervising/collaborating physician at the practice site.

*Prescriptive authority*⁴⁰

- PAs are authorized to prescribe Schedule II-V medication in 44 states.
- PAs lack the authority to prescribe Schedule II medication in six states (AL, AR, GA, HI, IA, WV).
- PAs lack the authority to prescribe legend drugs in one state (KY). Legend drugs are approved by the U.S. Food and Drug Administration and require a prescription by a licensed provider to be dispensed to a patient. Federal and state law specify which providers have authority to prescribe legend drugs.⁴¹

The AMA Brief reports that Michigan PAs are no longer required to work under the supervision or delegation of a physician.⁴² Rather, PAs are now required to work with a participating physician under the terms of a practice agreement.⁴³ PAs have prescriptive authority of Schedule II–V drugs and do not require a co-signature by physicians on their documentation. Michigan PAs are however, required to work under the scope of practice determined at the practice site.⁴⁴

While PA professional organizations advocate for a more autonomous role, the AMA:

[O]pposes enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the state's requirements for licensure to engage in the practice of medicine and surgery. The AMA believes that physicians must maintain the ultimate responsibility for coordinating and managing the care of patients, and with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.⁴⁵

The Michigan Academy of Physician Assistants (MAPA), however, proudly published a statement about the signing of Public Act 379 by Governor Snyder in December 2016, which advanced PA practice to its fullest potential in Michigan.⁴⁶ As stated in the MAPA Legislative Alert, "The 'Good News' from this bill is that the terms 'Supervision' and 'Delegation' are removed from the statute when referring to PA-physician teams and PAs are no longer delegated prescribers, but 'independent prescribers within a practice agreement'."⁴⁷

Education

In March 2018, the United States had 250 PA programs with competitive admission requirements for entry.⁴⁸ PAs are educated at the master's degree level, completing an average of three academic years of didactic, laboratory, and clinical study and training.⁴⁹ Didactic courses include human anatomy and physiology, pathophysiology, pharmacology, clinical medicine, physical diagnosis, and medical ethics. Additionally, PA students complete between 2000-3000 hours of clinical rotations in medicine (family, internal, obstetrics, and pediatrics), general surgery, emergency medicine and behavioral health.⁵⁰ These clinical rotations reinforce classroom education and may lead to employment opportunities for the successful student.^{51 52}

There are six accredited programs in Michigan with academic and curriculum oversight provided by the Michigan Task Force on Physicians Assistants.⁵³ This is a state board with statutory authority for regulating physician assistant training, licensure and discipline.⁵⁴ Similarities between the Michigan-based programs reflect the didactic, laboratory, and clinical rotations that must be offered to meet accreditation requirements. All programs have incorporated evidence-based medicine applications to ensure students are learning state of the art medicine. Program distinctions are reflected by the program's mission, the history of each program, and the roots established in a community to meet an essential urban or rural clinical need. The development of critical thinking skills and synthesis of medical decision making have evolved into creative curriculum models, requiring applicants to thoroughly research each program before applying only to those that best meets their needs.

Table 1 provides contact information about each program, with a link to each program’s website for further review.

Table 1: Physician Assistant Programs in Michigan⁵⁵

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AAPA provides some guidance on how education requirements will evolve in all PA programs across the United States through the Optimal Team Practice Guidelines policy it adopted in May 2017.⁵⁶ This policy focuses on the PA’s commitment to team-based care and the need to align the PA profession to meet present day healthcare needs. Changes made to state law in Michigan and other states were specifically acknowledged in adopting this policy.^{57 58}

The AAPA explains that only laws passed by each state will directly affect education changes.⁵⁹ However, this policy was codified in policy for the PA profession by the AAPA House of Delegates and was developed in concert with the Joint Task Force on the Future of PA Practice Authority, which include PA Program faculty.⁶⁰ Ultimately, changes made to admission practices and curriculum will result from the evolving market place, health care needs, and patient populations to be served. Regardless of whether state law requires practice agreements in lieu of working under the supervision of a physician, the new policy recommends that new graduates, early career PAs, and PAs changing specialties practice in teams with physicians, with their individual scope of practice determined by their own practice level.⁶¹ The goal of this policy is to encourage all PAs to consult with physicians and other members of the team to ensure that the

standard of care is always met.⁶² The policy further recommends that rather than requiring an agreement with a specific physician, a new PA graduate should report to or be supervised by a physician, a senior PA, or a chief PA. This will foster mentorship between physicians and PAs with the assurance of a strong consultation and clinical network in place to ensure optimal patient care.⁶³

Once a PA completes an accredited program, all states and the District of Columbia require PAs to be licensed before practicing in its jurisdiction.⁶⁴ This requires passing the Physician Assistant National Certifying Exam (PANCE) from the National Commission on Certification of Physician Assistants (NCCPA).⁶⁵ Once a PA passes the exam, the credential “Physician Assistant-Certified” (PA-C) may be used. PAs must complete 100 hours of continuing education every two years and pass a recertification exam every 10 years.⁶⁶

Advanced Practice Registered Nurses with Focus on Nurse Practitioners

History and Milestones

Nurse anesthetists, nurse midwives, and nurse practitioners all fall under the umbrella of Advanced Practice Registered Nurses (APRNs), with their scope of practice varying by state. Part One of this paper will focus primarily on Nurse Practitioners (NPs).⁶⁷ Part Two will discuss Public Act 499 of 2016, which created a new category of specialty-certified RNs in Michigan, and includes:⁶⁸

- Certified Nurse Practitioners
- Certified Nurse Midwives
- Clinical Nurse Specialists – Certified

The American Association of Nurse Practitioners (AANP) defines NPs as, “licensed, autonomous clinicians focused on managing people’s health conditions and preventing disease.”⁶⁹ As Advanced Practice Registered Nurses (APRNs), NPs specialize in their area of practice by patient population, such as pediatric, adult-gerontologic, or women’s health. NPs may specialize in more than one clinical area and can further subspecialize in areas like oncology, cardiovascular health, and dermatology. This is different than PA preparation, which only allows general medicine education. Specialization for PAs comes later through experience and continuing education.⁷⁰

The origin of the American Academy of Nurse Practitioners (AANP) began in 1985 with a group of visionaries who believed that NPs had a big role in positively impacting healthcare.⁷¹ The organization was established to unify NP voices and articulate a cohesive mission statement and plan for APRNs.⁷² Milestones up to that time included the development of NP programs and the growth of NP graduates throughout the country.⁷³ In 1979, there were approximately 15,000 NPs in the U.S; by 1983, there were about 24,000 NPs in the U.S.⁷⁴

Milestones from 1986-2018 include:

In 1986, the AANP started to affect national legislation on professional licensure, patient safety and healthcare reform.⁷⁵

In 1989, 90% of the NP programs were either master or post-master degree programs.⁷⁶

In 1994, “Advanced Practice Nursing-Good Medicine for Physicians” was published in *The New England Journal*. This article supported the contributions of NPs to improve quality of care and lower health care costs.⁷⁷

In 2005, NPs celebrated 40 years of practice and the AANP celebrated 20 years as the oldest and largest national organization for NPs of all specialties. There were 20,000 individual members and 115 group members.⁷⁸

In 2009, there were approximately 130,000 NPs in the U.S.⁷⁹

In 2010, the AANP became an important participant at meetings with the Centers for Medicare and Medicaid Services and the White House on health care reform, preventive care, quality of care, and reimbursement of non-physician providers. There were approximately 140,000 NPs in the U.S.⁸⁰

On January 1, 2013, the AANP and the American College of Nurse Practitioners formed the American Association of Nurse Practitioners, which is the largest full-service national professional organization for NPs of all specialties.⁸¹

As of 2018, there are more than 248,000 NPs in the U.S. with 86.6% certified in an area of primary care.⁸² The five top practice settings are Hospital Inpatient, Hospital Outpatient, Psychiatric and Mental Health, Private Group Practice, and Long-Term Care. The average full-time salary is \$105,546.⁸³

Scope of Practice

Professional education standards, state law, administrative rules and regulations, and case law also define the scope of practice for APRNs.⁸⁴ The American Association of Nurse Practitioners defines generic practice activities of its professionals by the education completed at an accredited program.⁸⁵ Through academic preparation, NPs are qualified to assist in the process of care, which includes health assessment, diagnosis of conditions and illnesses, treatment plan development and implementation, and conducting follow-up evaluations of patients.⁸⁶ NPs are prepared to promote preventive and wellness care of the patient and family.⁸⁷ They are qualified to collaborate with other health care providers in carrying out a healthcare plan.⁸⁸ NPs are specifically known for their patient care advocacy and championing the delivery of quality care at the highest levels.⁸⁹

Educational preparation standards defined by professional organizations or academic institutions, however, are not binding, and do not hold the force of law in defining scope of practice.⁹⁰ The NPs specialization and state laws in which individuals practice direct the actual duties and responsibilities of APRNs.⁹¹ States granting full practice rights allow APRNs to assess patients, diagnose conditions, order diagnostic exams, and provide treatment under the authority of their regional state board of nursing.⁹² Reduced-practice states require collaboration with another health care provider in at least one aspect of NP practice.⁹³ Restricted states require direct supervision of at least one element of NP practice.⁹⁴ Michigan is a restricted state.⁹⁵

Since NPs are licensed as Registered Nurses (RNs) in Michigan, NP scope of practice is defined through the RN scope of practice.⁹⁶ Stated differently, there is no separate scope of practice defined for NPs in Michigan.⁹⁷ Therefore, NPs can practice those duties and responsibilities that fall within the scope of the RN license without direct physician supervision.⁹⁸ The law, however, expressly prohibits some duties from being performed by the RN unless under direct physician supervision.⁹⁹ This includes practicing medicine, defined by the key duties of diagnosing, treating, preventing, or relieving a patient from disease, ailment, or complaint.¹⁰⁰ In Michigan, even though a NP is academically prepared to complete these duties, they cannot perform these tasks unless they are supervised by a physician.¹⁰¹

NPs hold prescriptive privileges in all 50 states.¹⁰² In Michigan, NPs may prescribe non-scheduled drugs without the delegation of a physician.¹⁰³ A NP may only prescribe Schedule II–V controlled substances if delegated by the supervising physician.¹⁰⁴

Education

The APRN designation means that professionals have completed a master's or doctoral degree program and have advanced clinical training beyond their RN designation.¹⁰⁵ Prior to practice, these providers must meet rigorous national certification requirements and participate in periodic peer reviews and clinical outcome evaluations to ensure clinical competence.¹⁰⁶ While PAs are taught under the medical model, APRN training focuses on disease prevention, health promotion, education, and counseling.¹⁰⁷ NPs teach patients how to prevent disease and maintain health by making wise lifestyle, food, and fitness choices.¹⁰⁸ This focus has resulted in fewer emergency room visits, shorter hospital stays, and lower medication costs.¹⁰⁹ The care, mentorship, and education provided by APRNs result in over 870 million visits each year by patients who have expressed high satisfaction with the level of care received.¹¹⁰

Most APRN education programs prefer applicants who have already earned a bachelor's degree in nursing.¹¹¹ Some programs offer creative curriculum models to bridge someone with an associate's degree or diploma in nursing to a bachelor's degree in nursing.¹¹² For an RN desiring to become a NP, master's degree programs are the most common entry point for this education.¹¹³ However, there are programs that offer a Doctor of Nursing Practice (DNP) or a PhD in Nursing.¹¹⁴ Similar to PA programs, the APRN NP program includes didactic instruction and clinical experience. Common courses are anatomy, physiology, and pharmacology, with specific coursework focused on the APRN role of wellness and preventive medicine.¹¹⁵

NPs must graduate from a program accredited by the Commission on Collegiate Nursing Education (CCNE) or the Accreditation Commission for Education in Nursing (ACEN).¹¹⁶ CCNE accredits programs that offer either a Bachelor or Master's degree of Science in Nursing.¹¹⁷ ACEN accredits nursing certificate and diploma nursing programs all the way through post-master's and clinical doctorate programs.¹¹⁸

In summary, the generic requirements to become an NP require the individual to:

1. Earn a nursing undergraduate degree from an accredited program;
2. Become a registered nurse by passing the National Council Licensure Examination (NCLEX-RN) Exam;
3. Complete a graduate degree in the field of nursing from an accredited program;
4. Obtain an Advanced Practice Nursing license by passing the national certification exam; and
5. Obtain certification in a specific patient population focus.¹¹⁹

Michigan NPs hold a master's degree in nursing with either a specialization in advanced practice nursing or a certificate in advanced practice nursing in addition to a traditional nursing master's degree.¹²⁰ NPs can be certified in Adult, Family, Gerontological, Pediatric, Adult Acute Care Medicine, and Adult Psychiatric and Mental Health Diabetes Management.¹²¹

NPs must meet continuing education requirements for their RN license and NP certification. The RN license requires earning 25 contact hours for every two-year licensing period.¹²² Beginning with the March 2018 renewals, two of these hours must be in pain and symptom management.¹²³ Additionally, there is a one-time requirement for training in identifying victims of human trafficking.¹²⁴ Further, Certified NPs must maintain national certification with the certifying body of the clinical specialty. For this, requirements vary by specialty.¹²⁵

The AANP website (at <https://npprogramsearch.aanp.org/Search/Results>) provides a list of the 13 NP programs available in Michigan as of 2015. The website identifies whether the program offers traditional classroom and/or distance learning opportunities and the available certification specialties. The AANP website provides a link to access each program's website to learn about the specific offerings at each school.¹²⁶ Programs that stand out are those with strong mission and value statements, robust clinical rotations, and courses that spotlight leadership skills for future NP leaders.¹²⁷

In considering the educational preparation of NPs to the state of nursing practice today, the Michigan Nurses Association asserts that,

Nurses are trusted by the public and known for their ethics, expertise, commitment, and compassion. Our nursing agenda should expand beyond professional aspirations and also focus on becoming more relevant and involved in the policy discussions on the future shape of health care. The Michigan Public Health Codes allows the Board of Nursing to issue a specialty certificate to RNs who have acquired advanced training beyond that required for initial licensure and demonstrated competency through examination or other evaluation processes.¹²⁸

According to the American College of Nurse Practitioners, NPs address the most common conditions that patients present with including chronic illnesses.

A nurse practitioner focuses largely on health maintenance, disease prevention, counseling, and patient education in a variety of settings. With a strong emphasis on primary care, nurse practitioners are employed in several areas, including

pediatrics, school health, family and adult health, women’s health, mental health, home care, and geriatrics.¹²⁹

It is paramount then, for educational programs to continually support the nursing profession in its work by offering state of the art academic programs.

Legislative Impact of PA and APRN Practice

Physician Assistants and Nurse Practitioners are both included under the Advanced Practice Provider (APP) umbrella. Their education and scope of practice determined by law, defines what they can and cannot do. While these providers are distinct from one another, together they are essential in the delivery of healthcare throughout the United States.¹³⁰ The passage of the Affordable Care Act (ACA) uniformly affected both professions.¹³¹

The National Physicians Alliance summarized the 2010–2014 timeline for implementing ACA objectives.¹³² Table 2 summarizes those objectives that have more directly impacted APPs.¹³³

Table 2: Affordable Care Act Objectives Impacting PAs and NPs¹³⁴

2010	-Create new incentives to expand the number of primary care doctors, nurses, physician assistants -Increase payments for rural health care professionals -Extend coverage for young adults -Require all new plans to cover certain preventive services without charging a deductible, co-pay or co-insurance
2011	-Provide 10% bonus payments for primary care services -Provide no-cost preventive care for seniors on Medicare, like annual wellness visits
2012	-Encourage coordinated care through organized medical team organizations -Reduce paperwork and administrative costs by making billing and documentation more efficient
2013	-Improve preventive health coverage by providing new funding to state Medicaid programs that choose to cover preventive services for patients at little or no cost
2014	-Prohibit insurers from discriminating against patients with pre-existing conditions -Eliminate annual limits on insurance coverage

These objectives, along with the shortage of doctors, the increased number of people with health care coverage, and the pressure to reduce health care costs placed a huge burden on the United States health care system.¹³⁵ However, with this came recognition of PA and NP contributions to reduce lengths of stay and readmission rates, and improve the overall quality of health care.¹³⁶ In acknowledgement of these contributions, state governments took significant steps to offer APPs full authority without requiring a supervising or collaborative physician.¹³⁷ Similarly, 21 states passed legislation offering NPs the ability to attain full practice authority.¹³⁸ Further, the Centers for Medicare and Medicaid Services demonstrated its recognition of PAs and NPs by including physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse anesthetists alongside physicians as providers in its Quality Payment Program (QPP).¹³⁹ This program incentivizes physician and non-physician providers to deliver quality care at a reduced cost. Key objectives are to: a) improve health care to all beneficiaries; b) lower costs through improvement of care and health; c) educate and empower patients as members of their care team; d) maximize

QPP participation in small, rural, and underserved areas; and e) expand participation in alternative payment and reimbursement models of physician and non-physician providers.¹⁴⁰

Four years after the ACA was passed, The Heritage Foundation published, *The Impact of the Affordable Care Act on the Health Care Workforce*.¹⁴¹ In this article, its author, Anderson, asserted that the ACA would exacerbate the healthcare work shortage and work in opposition to the constructive goals it was meant to achieve.¹⁴² Providers would become stressed from treating more patients and meeting the paperwork requirements.¹⁴³ Further, legislation passed to reduce payments and increase penalties would ultimately push providers from private practice. This would result in putting Americans at risk for receiving less than optimal health care.¹⁴⁴

Anderson concluded her article with recommendations to balance legislative changes, the role of policy makers, and education and training initiatives for all providers. She explained that primary care and specialty care should be delivered with a better understanding of who the patient is by urban and rural areas.¹⁴⁵ Graduates of all health care professions need to increase. Faculty need to be financially incentivized to build more creative models to better prepare all providers to meet the needs of a patient base. She also recommended that Congress become more involved in evaluating health care needs with Graduate Medical Education Programs.¹⁴⁶ Important to promoting optimal health care delivery is creating clinical rotations with more hands-on opportunities to directly impact patient treatment and their wellbeing. Better use of scholarships and grants is necessary to motivate students and faculty to improve education and set up practice where it is most needed. Incentives should be awarded to successful candidates who complete their education, licensure, and certification requirements. In doing this, access to care barriers will be addressed by placing educational programs and healthcare facilities where they will do the greatest good. In conclusion, legislators should seek sensible changes to ensure that legislation works in concert with health care provider preparation and practice.¹⁴⁷

Conclusion

This academic review of PA and APRN history and milestones, scope of practice, education, and legislative impact demonstrates that both professions were created from a need in this county to ensure that all patients are treated with quality healthcare. The need for both professions is as profound as ever. While scope of practice for both professions is directed by legislation, this is only one part in delivering comprehensive, cohesive, and competent healthcare in the United States.

PART TWO

Analysis of Changes in Legal Scope of Practice for PAs and APRNs

By Kathleen A. Reed

Physician's Assistants

Change in Paradigm for Defining PA Scope of Practice

Prior to PA 379 of 2016, the Code defined “practice as a physician’s assistant” as “the practice of medicine, osteopathic medicine and surgery, or podiatric medicine and surgery performed under the supervision of a physician or podiatrist licensed under this article.”¹⁴⁸ Effective March 22, 2107, PA 379 redefined “practice as physician’s assistant” as “the practice of medicine with a participating physician under a practice agreement.”¹⁴⁹ This change constitutes a paradigm shift away from defining PA practice under the “delegation and supervision” provisions of the Michigan Public Health Code (Code), to defining PA practice as the practice of medicine under a written practice agreement. The technical requirement that a physician delegate medical tasks to a PA and then supervise the PA’s performance of those tasks is gone. Now, PAs practice collaboratively with participating physicians under practice agreements. However, as discussed below, many elements of the old delegation/supervision paradigm have been incorporated into the required elements of a practice agreement, and into the new statutory obligations of the PA and the participating physician. It is also important to note that PA 379 did not change the PA’s status as a “subfield” health professional licensee.¹⁵⁰ This means that although a PA is considered to be practicing medicine, the PA may not himself or herself delegate medical tasks to or supervise another individual’s performance of medical tasks.¹⁵¹

In addition to eliminating the requirements for compliance with the Code’s delegation and supervision provisions, PA 379 also eliminated other technical barriers to a more independent practice by the PA. First, the Code no longer restricts the PA to treating patients who are already under the physician’s “case management responsibility.”¹⁵² This means that the PA may see and treat the patient before the participating physician sees the patient. This is of great practical importance in urgent care, emergent care, and rural and telemedicine settings. Second, PA 379 removed the prohibition against the physician’s delegating ultimate responsibility for the quality of medical care services to the PA.¹⁵³ Regardless of whether this change will have any practical effect on the participating physician’s legal liability for care provided by a PA, it is symbolic of the increased independence and responsibility of the PA for the care he/she provides. Third, a PA is now officially included in the definition of “prescriber” and is no longer required to record on a prescription, or on a receipt for starter doses, the name and DEA number (for controlled substances) of the participating physician.¹⁵⁴ Finally, PA 379 eliminated the requirement that the physician keep a written log of the number of PAs practicing with the physician and eliminated the strict maximum number of PAs with whom a physician may practice.¹⁵⁵

While PA 379 may have deleted these indicia of delegation and supervision, it imposed other new requirements on PA practice and on the relationship between the PA and the collaborating physician. The most significant requirement is that the PA enter into and practice within the terms

of a compliant, written practice agreement with a participating physician.¹⁵⁶ This requirement is incorporated directly into the definition of practice as a PA, so that practicing without a written practice agreement or in violation of the terms of a practice agreement may subject both the PA and the participating physician to penalties for professional misconduct.¹⁵⁷ The requirements for a compliant practice agreement are described in the next section.

PA 379 imposes another new requirement on the relationship between the PA and the participating physician that may make the scope of collaborative tasks more restricted than was possible under the old delegation/supervision paradigm. Under the previous delegation/supervision paradigm, a physician could delegate to a PA any task that was within the scope of the delegating physician's license, even if the physician did not have training in or experience with the specific delegated task.¹⁵⁸ Under the new paradigm, a practice agreement may not include "an act, task, or function that the physician's assistant or the participation physician is not qualified to perform by education, training, or experience" as a duty or responsibility of the PA or the participating physician.¹⁵⁹ Thus, both the participating physician and the PA must have education, training, and expertise for a given task before it may be included within the practice agreement and performed by the PA. A PA and a physician may no longer collaborate on a task for which the PA has experience, but the physician does not, or vice versa. This requirement will be important for health care institutions to consider when granting clinical privileges to PAs and their participating physicians.

Under the new paradigm, the Boards of Medicine, Osteopathic Medicine and Surgery, and Podiatric Medicine and Surgery have authority to prohibit or restrict tasks from being included in a practice agreement, if a Board finds that a particular medical care service "requires extensive training, education, or ability or poses serious risks to the health or safety of patients."¹⁶⁰ Similarly, the Michigan Department of Licensing and Regulatory Affairs (LARA), in consultation with the Boards, may promulgate rules concerning prescribing activity by PAs, including designations of drugs or classes of drugs that a PA may not prescribe, or "other procedures or protocols necessary to promote consistency with federal and state drug control and enforcement laws."¹⁶¹ At the date of this writing, neither LARA nor the Boards have issued rules or pronouncements to this effect.

Practice Agreement Requirements

PA 379 prohibits a PA from practicing except under the terms of a practice agreement that meets all of the following requirements:¹⁶²

- (a) Includes a process between the PA and the participating physician for communication, availability, and decision making when providing treatment to a patient. The process must use the knowledge and skills of the PA and the participating physician based on their education, training, and experience;
- (b) Includes a protocol for designating an alternative physician for consultation in situations when the participating physician is not available;
- (c) Is signed by the PA and the participating physician;

- (d) Includes a termination provision that allows the PA or the participating physician to terminate the agreement by providing written notice at least 30 days prior to the termination date;
- (e) Shall not include as a duty or responsibility of the PA or the participating physician an act, task, or function that the PA or the participating physician is not qualified to perform by training, education or experience and that is not within the scope of the license held by the PA or participating physician; and
- (f) Includes a requirement that the participating physician verify the PA's credentials.

Note that some the required elements of the previous delegation/supervision paradigm are carried over into the required elements of a practice agreement, including the continuous availability of a physician for consultation, and the physician's duty to confirm the PA has the credentials (education, training, and experience) to perform the medical task.

There is no requirement that a PA report or submit a copy of a practice agreement to LARA, a licensing board, or to any other regulatory body. However, federal controlled substance regulations require all midlevel practitioners with a Drug Enforcement Administration ("DEA") registration, including PAs, to maintain all documents evidencing the practitioner's authority to prescribe controlled substances, including practice agreements, and to make them readily available for inspection and copying by DEA officials.¹⁶³ This federal requirement and general good recordkeeping practices suggest that the PA maintain signed copies of all applicable practice agreements in a secure and accessible location.

PA 379 does not specifically restrict how many PAs with whom a physician may enter into a practice agreement but does make the physician's decision regarding that number "subject to Section 16221."¹⁶⁴ Presumably, this means that a physician who enters into practice agreements with more PAs than the applicable medical standard of care would suggest is reasonable, may be subject to discipline for professional misconduct under Section 16221 of the Code. PA 379 also does not restrict the PA from entering into practice agreements with more than one participating physician.¹⁶⁵ However, the PA should use caution to avoid entering into multiple practice agreements where the agreements create confusion or inconsistency with regard to which medical tasks the PA is performing in collaboration with each participating physician.

Prescribing Authority and Practice

As mentioned above, PA 379 amended the definition of "prescriber" in the Code to include PAs.¹⁶⁶ This means that a PA may write prescriptions for drugs, including controlled substances, independently under the PA's own name and DEA number, without using or otherwise recording the name or DEA number of the participating physician. In the past, federal controlled substance regulations and the DEA have required PAs to obtain and use their own DEA registration number when prescribing controlled substances.¹⁶⁷ PA 379 did not affect this federal requirement. However, prior to PA 379, LARA did not require (or even permit) a PA to obtain a Michigan controlled substance license, because the PA was considered to be prescribing controlled substances as a delegated function under the delegating physician's Michigan controlled substance

license. As the result of PA 379, a PA prescribes controlled substances independently, and must, therefore, obtain his or her own Michigan controlled substance license.¹⁶⁸ A PA who prescribes controlled substances without his or her own Michigan controlled substance license may be in violation of the controlled substance provisions and the professional misconduct provisions of the Code.¹⁶⁹

Professional Misconduct by a PA or Participating Physician

Because “practice as a PA” is now defined as the practice of medicine with a participating physician pursuant to a compliant practice agreement, a PA who practices without a practice agreement or practices with a non-compliant practice agreement may be considered practicing outside the scope of a PA license.¹⁷⁰ Practicing outside the scope of a PA license may subject a PA to discipline for professional misconduct.¹⁷¹ Additionally, the PA and the participating physician may both be subject to professional discipline for failure to comply with the terms of a practice agreement.¹⁷² Problematic activity might include failure to follow the protocol for collaboration and coverage, undertaking tasks not contemplated under the practice agreement, or failure of the participating physician to verify the PA’s credentials. Additionally, as mentioned above, the appropriateness of the number of PAs with whom a participating physician enters into a practice agreement is a matter that may be subject to professional discipline.¹⁷³ The Boards of Medicine, Osteopathic Medicine and Surgery, and Podiatric Medicine and Surgery have the authority to deny or limit a PA’s or a physician/podiatrist’s ability to enter into a practice agreement based on a determination of professional misconduct by the PA or the physician/podiatrist, respectively.¹⁷⁴ For a PA, such a determination could have a devastating effect on the PA’s practice, because a PA is unable to practice without a practice agreement in place.¹⁷⁵

Advanced Practice Registered Nurses

Who Qualifies as an Advanced Practice Registered Nurse?

Public Act 499 of 2016 created a new category of specialty-certified registered nurse (RN) in Michigan, the Advanced Practice Registered Nurse (APRN). The APRN category includes the following types of specialty-certified RNs:¹⁷⁶

- Certified Nurse Practitioners
- Certified Nurse Midwives
- Clinical Nurse Specialists – Certified

Note that this list does not include certified registered nurse anesthetists (CRNAs), a type of specialty certification available to RNs in Michigan. Accordingly, the expanded scope of practice available to APRNs described in this paper is not applicable or available to CRNAs at this time.

The APRN category includes a new type of specialty-certified RN, the clinical nurse specialist – certified (CNS or CNS-C), also added under PA 499.¹⁷⁷ A CNS customarily has expertise in providing care, treatment, and planning for specific patient populations, specific diseases or conditions, or specific patient or care settings.¹⁷⁸ CNS specialty certification, and the ability to

practice the expanded scope of an APRN, became available on March 8, 2018, the effective date of rules specifying the educational and other criteria required for CNS specialty certification.¹⁷⁹ Until March 8, 2019, RNs who have not obtained specialty certification as a CNS may continue to use “CNS” or similar titles to signify their academic or educational credentials without violating the Code, but such an educationally-prepared (but not officially certified) CNS may not engage in the expanded scope of practice of an APRN.¹⁸⁰ After March 8, 2019, only RNs who have been awarded CNS specialty certification may hold themselves out as and use the title “CNS.”¹⁸¹ An RN who obtains CNS specialty certification may assume the expanded duties of an APRN upon receiving CNS specialty certification.¹⁸²

Changes to legal scope of practice for an APRN

As described in Part One, specialty certification itself does not expand the legal scope of practice of an RN in Michigan, as defined in the Code. Specialty certification does, however, provide evidence of training, education, and experience that makes an RN qualified to accept delegation of medical tasks from a physician under Section 16215 of the Code. In contrast, changes to the Code resulting from PA 499 expanded the legal scope of practice of those specialty-certified RNs who fall into the APRN category to include the following specific tasks, which the APRN may perform independently:

- Write a prescription for a non-scheduled prescription drug;¹⁸³
- Order, receive, and dispense complimentary starter doses of non-controlled substances using, recording, or otherwise indicating only the name of the APRN;¹⁸⁴
- Refer a patient to a speech-language pathologist for assessment, treatment, therapy, and services related to swallowing disorders and medically-related communication disorders;¹⁸⁵
- Prescribe physical therapy services;¹⁸⁶
- Provide notice of HIV test results and counseling to marriage license applicants;¹⁸⁷
- Make and document a determination that it is medically contraindicated to provide a patient or resident in a licensed health facility or agency information about his or her medical condition, proposed course of treatment, and prospects for recovery;¹⁸⁸
- Make and document a determination that it is medically contraindicated to permit a patient or resident in a licensed health facility or agency to have private communications with individuals of his or her choice, or to send or receive unopened private mail;¹⁸⁹
- Make and document a determination that it is medically contraindicated to permit a patient or resident in a licensed health facility or agency to meet with and participate in the activities of social, religious, and community groups at his or her discretion;¹⁹⁰

- Authorize the use of chemical or physical restraints for a patient or resident in a licensed health facility or agency, in accordance with permitted parameters;¹⁹¹
- Make and document a determination that it is medically contraindicated for married residents of a nursing home or home for the aged to share a room;¹⁹²
- Make and document a determination that it is medically contraindicated for a resident of a licensed nursing home or home for the aged to retain and use his or her personal clothing and possessions;¹⁹³
- Make and document a determination that it is medically contraindicated for a resident of a licensed nursing home or home for the aged to be fully informed about the resident's medical condition;¹⁹⁴
- Make and document a determination that it is medically contraindicated for a nursing home resident to receive treatment by a licensed health care provider that has been requested by the resident;¹⁹⁵ and
- Make and document a determination that a nursing home resident is terminally ill for purposes of permitting the resident's parents (if a minor), spouse, next of kin or patient representative (if adult) to stay at the facility 24 hours a day.¹⁹⁶

PA 499 clarified that there are no limitations on the locations at which an APRN may conduct this expanded scope of practice, and that there are no restrictions or requirements regarding the timing or frequency with which a physician or an APRN visits the patient.¹⁹⁷ The statute notes specifically that an APRN “may make calls or go on rounds in private homes, public institutions, emergency vehicles, ambulatory care clinics, hospitals, intermediate or extended care facilities, health maintenance organizations, nursing homes or other healthcare facilities.”¹⁹⁸

The expansion of an APRN's scope of practice under PA 499 beyond what is permitted for a RN under the Code is limited to the specific tasks enumerated above. Thus, an APRN in Michigan may independently (without delegation and supervision from a physician or dentist) perform any task that is considered within the Code's definition of the practice of a RN, plus any of the specific tasks listed above.¹⁹⁹ Other tasks that may be commonly performed by APRNs, including making diagnoses and ordering lab tests and other diagnostic procedures, are not within an APRN's legal scope of practice as defined under the Code, and must be delegated and supervised by an individual licensed to perform that task.²⁰⁰ This creates a practical problem because some of the tasks which an APRN may now perform independently are necessarily reliant upon or associated with tasks that an APRN may only perform as a delegated and supervised task. For example, while an APRN may prescribe insulin for a patient on an independent basis, it is not within the APRN's independent legal scope of practice as defined in the Code to make the medical diagnosis of diabetes upon which the insulin prescription is based.²⁰¹ This suggests that many APRNs will be practicing in a hybrid scenario, where some of their tasks may be performed independently and some may only be performed under the delegation and supervision of a physician.

Prescribing Authority and Practice

PA 499 of 2016 permits an APRN to prescribe a non-controlled drug independently and includes an APRN within the definition of “prescriber” for purposes of prescribing non-controlled drugs.²⁰² This means the APRN may prescribe a non-controlled prescription drug without delegation or supervision by a physician, and without having to record a physician’s name or obtain a physician’s signature in connection with the non-controlled drug prescription. Additionally, an APRN may now order, receive, and dispense complimentary starter doses of non-controlled drugs without delegation from a physician.²⁰³ Only the APRN’s name is required to be used or recorded in connection with the order, receipt or dispensing complimentary starter doses of non-controlled drugs.²⁰⁴

In contrast, an APRN may prescribe Schedule II–V controlled substances only as a *delegated* act of a physician.²⁰⁵ When prescribing a controlled substance as a delegated act, the APRN must record or use both the APRN’s and the delegating physician’s name and DEA registration number in connection with the prescription.²⁰⁶ Similarly, an APRN may order, receive, and dispense complimentary starter doses of controlled substances (Schedule II–V) only as a delegated act of a physician and must use, record, or otherwise indicate both the APRN’s and the physician’s name and DEA number in connection with ordering, receipt, and dispensing of controlled complimentary starter dose drugs.²⁰⁷ This delegation mechanism for APRN controlled substance prescribing is further described in FAQs posted on LARA’s website.²⁰⁸ In response to email queries, LARA advises that an APRN who is writing controlled substance prescriptions using the DEA registration of the institution where the APRN is employed or under contract (as permitted by controlled substance federal regulations²⁰⁹) may use or record that institutional DEA registration number on the controlled substance prescription. LARA’s FAQs further clarify that an APRN is not required (or permitted) to obtain a Michigan controlled substance license, because the APRN may prescribe controlled substances only as a delegated task under the physician’s Michigan controlled substance license.²¹⁰

Prior to the effective date of PA 499, the Board of Medicine had promulgated rules regarding the delegation of authority to prescribe Schedule II–V controlled substances to an RN with a specialty certification, except a CRNA.²¹¹ Although the rule predates PA 499, it is not in conflict with PA 499 or the Code and, therefore, should be considered applicable to APRN and physician practice. This rule states that a physician may delegate prescriptive authority for Schedule II–V controlled substances to a NP or CNM only pursuant to a written authorization containing the following information:²¹²

- Name, license number and signature of the delegating/supervising physician;
- Name, license number and signature of the specialty certified RN;
- The limitations or exceptions to the delegation; and
- The effective date of the delegation.

The delegating/supervising physician must review and update the written authorization annually (based on the date of the physician's signature), noting the review date on the written authorization.²¹³ Any amendment to the written authorization must meet the requirements of the rule.²¹⁴ The delegating/supervising physician must maintain a copy of the written authorization at the physician's primary place of practice, and provide a copy to the specialty-certified RN.²¹⁵ The rule prohibits the physician from authorizing a NP or CNM to issue a prescription for a Schedule II controlled substance with a quantity greater than a 30-day supply.²¹⁶ Beginning July, 1, 2018, this 30-day limit will be further reduced by recent legislation that limits prescriptions for opioids to a 7-day supply within a 7-day period when being used to treat acute pain.²¹⁷ Finally, the rule specifies that a physician may not delegate the prescription of a drug or device individually, in combination, or in succession for a known-pregnant woman with the intent to cause a miscarriage or fetal death.²¹⁸

Use of a Collaboration Agreement

Neither the APRN independent practice provisions of the Code²¹⁹ nor the delegation and supervision provisions of the Code²²⁰ require an APRN to have any form of written collaboration agreement between the APRN and a physician. The only legal requirement for a written memorialization of collaborative practice between an APRN and a physician is the requirement in the Board of Medicine rules for a written authorization of the delegation of prescriptive authority for controlled substances mentioned above.²²¹ Thus, an APRN whose practice includes both independent acts (e.g., prescribing non-controlled substances) and delegated/supervised acts (diagnosing) is not required by the Code or Michigan administrative rules to have any form of written collaboration agreement with a physician, *unless* the APRN is prescribing controlled substances.

Despite this lack of legal requirements for written collaboration agreements (except for delegation of controlled substance prescribing), both Medicare and Michigan Medicaid impose some requirements regarding collaboration agreements for certain types of APRNs. In the case of Medicaid, the Michigan Medicaid Provider Manual requires that a CNM "be able to demonstrate a safe mechanism for physician consultation, collaboration, and referral within an alliance agreement that includes mutually approved protocols."²²² This requirement would be difficult, if not impossible, to meet without a written collaboration or alliance agreement. For NPs who are enrolled in Medicaid as an "individual/sole provider" and receiving direct reimbursement from Medicaid, the NP must "provide services according to the terms of a written collaborative practice agreement in place with a physician."²²³ Medicaid defines the collaborative practice agreement as a "formal document" that describes the terms under which the NP and the physician will deliver medical services.²²⁴ The document should be mutually developed by the physician and NP, should describe "the types of services to be provided and any criteria for referral and consultation," and should be available to Medicaid upon request.²²⁵ Further, the services to be provided under the agreement must be within each provider's scope of practice under federal and state law.²²⁶

In contrast, the Medicare requirements regarding a written collaborative agreement are less clear. With regard to CNMs, the Medicare Benefits Policy Manual provisions on coverage of CNM services does not specifically reference collaboration agreements, stating only that the CNM must meet all state requirements regarding physician supervision and collaborative practice.²²⁷ For both

NPs and CNSs, the Medicare manual provisions require compliance with state law on collaboration.²²⁸ The provisions state “in the absence of state law governing collaboration, collaboration is to be evidenced by” the CNSs or the NPs documenting “their scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice.”²²⁹ Because Michigan does not have any specific law addressing collaboration arrangements between CNSs/NPs and physicians (other than the written authorization for controlled substance prescribing), these Medicare manual provisions suggest that Medicare expects written collaboration agreements for NPs and CNSs practicing in Michigan.

Even for APRNs who do not bill Medicare or Medicaid, use of a written, signed collaboration agreement with a physician may be considered a legal “best practice” for APRNs for several reasons. The most important reason to use a collaboration agreement is to document that the APRN is practicing within the APRN’s legal scope of practice. The collaboration agreement may be used to document which medical tasks the physician is delegating to the APRN and who is supervising the APRN’s performance of the delegated tasks in accordance with the Code. This may be useful in avoiding claims against the APRN for the unlicensed practice of medicine. This may also be useful in supporting a certification of compliance with applicable “laws, regulations, and program instructions” that an APRN may be required to make when submitting claims to Medicare, Medicaid or other government payers.²³⁰ Second, in addition to Medicare and Medicaid, some other third-party payers may require an APRN to have a written collaboration agreement in place as a condition to reimbursement. Third, many APRNs will be prescribing controlled substances and will need a written authorization with the delegating physician, which may be incorporated into a written collaboration agreement. Fourth, from a both a legal and logistical perspective, it is generally a good practice for parties who are working collaboratively to document their respective responsibilities and expectations prior to beginning collaborative practice.

Implications for Reimbursement of PAs and APRNs

Medicare

Medicare coverage for services provided by an APRN or a PA is limited to (otherwise covered) services that the APRN or PA is legally authorized to perform in accordance with state law.²³¹ In terms of Michigan law, “legally authorized” includes services included within the APRN’s or PA’s statutorily-defined scope of practice, and services which are appropriately delegated to an APRN under Article 15, Section 16215 of the Code. Thus, the expansion of a PA’s or APRN’s scope of practice under PA 379 or PA 499, respectively, does not affect Medicare coverage of PA or APRN services. Any new, independent functions being performed by a PA or APRN as a result of PA 379 or PA 499, respectively, were likely previously covered by Medicare because the PA/APRN was legally authorized to perform such tasks under the Code’s delegation provisions.²³²

Michigan Medicaid

Because the Michigan Department of Health and Human Services (“MDHHS”) has not yet updated the Michigan Medicaid Provider Manual (“Medicaid Manual”) in accordance with PA 379 and PA 499, it is difficult to determine what, if any, impact these laws will have on Medicaid

reimbursement for PAs and APRNs. For example, the Medicaid Manual still states that Medicaid covers service provided by a PA “under the delegation and supervision of a physician,” and that the physician must comply with the delegation and supervision requirements of the Code.²³³ As discussed above, PA 379 eliminated the delegation/supervision paradigm for PA practice in favor of practice under a compliant practice agreement.²³⁴ The Medicaid Manual does not currently mention practice agreements. As to CNMs, the Medicaid Manual states that a CNM can prescribe oral contraceptives or other pharmaceuticals only “under the delegation of a physician.”²³⁵ As an APRN, a CNM may now prescribe an oral contraceptive independently.²³⁶

However, in late June, 2018, MDHHS issued a Proposed Policy Draft titled “Update to the Coverage of Physician Assistant Services.”²³⁷ The proposed policy would require PA services to be “performed under the terms of a valid practice agreement with a Medicaid enrolled MD/DO” in order to be reimbursed by Medicaid.²³⁸ In addition, the proposed policy would require the PA to maintain the practice agreement at the PA’s primary practice location and to provide MDHHS with a copy upon request.²³⁹ The proposed policy also mandates that during Medicaid enrollment and enrollment revalidation, the PA must report the National Provider Identifier (NPI) of his/her Medicaid-enrolled participating physician.²⁴⁰ According to the proposed policy “(d)isenrollment of the participating physician from the program may prompt disenrollment of the PA.”²⁴¹ The draft document states that the policy change is proposed to be issued September 1, 2018, with an October 1, 2018 effective date. Presumably the Medicaid Manual will be updated in accordance with the proposed policy, once the policy becomes effective.

Despite the outdated Medicaid Manual provisions currently in effect and the pendency of the proposed PA policy, it is probably safe to assume that Medicaid will cover PA or APRN services provided in compliance with PA 379 or PA 499, respectively, if Medicaid otherwise covers those services. For example, PA services provided under a compliant practice agreement, or non-controlled drug prescriptions written by a CNM without physician delegation will likely be covered by Medicaid, provided they are otherwise not excluded from Medicaid coverage.

Commercial Insurance

Because PA 379 changed only the paradigm for PA practice and not the types of tasks a PA may perform, there was no need for commercial insurers to change their coverage or reimbursement parameters for PA services. However, in an effort to address the new requirement that each practicing PA have a compliant practice agreement with a participating physician, Blue Cross and Blue Shield of Michigan (“BCBSM”) required all PAs to re-enroll in BCBSM prior to January 31, 2018.²⁴² As part of the re-enrollment, each PA was required to complete a Physician Assistant Re-Enrollment Form, a Physician Assistant/Physician Practice Agreement Attestation Form, and a BCBSM Physician Assistant Combined Signature Document.²⁴³ PAs who re-enrolled with BCBSM prior to January 31, 2018, are eligible for reimbursement for services within the scope of their license.²⁴⁴ BCBSM has advised that it will deny claims filed by a PA who has not re-enrolled.²⁴⁵

In contrast, PA 499 of 2016 expanded the scope of practice of APRNs in Michigan to include several tasks that the APRN may now perform independently, most importantly prescribing non-controlled drugs.²⁴⁶ However, PA 499 specifies that it does not require new or additional third-

party reimbursement or mandated worker's compensation benefits relating to an APRN's ability to prescribe non-controlled drugs independently, or controlled substances as a delegated task.²⁴⁷ Thus, commercial and government payers are not required to provide reimbursement for prescriptions (controlled or non-controlled) written by APRNs, and are free to impose their own requirements as to who may write covered prescriptions. For this reason, it is important for an APRN to consult individual commercial insurers' coverage and reimbursement requirements for APRN services prior to writing a prescription for an insured. BCBSM, for example, has indicated that it considers an APRN to be an appropriate prescriber for non-controlled and Schedule II–V controlled substances prescriptions, provided both the APRN's and the delegating prescriber's names and DEA numbers appear on all Schedule II–V controlled substances, as required under Michigan law.²⁴⁸

Organizing in a Legal Entity

Physician's Assistants

In general, the fact that a PA and a participating physician have entered into a practice agreement together does not, itself, necessitate that the PA and the participating physician be shareholders, employees, agents, or otherwise affiliated with the same legal entity. However, because PAs are considered to be providing the same professional service (medicine and surgery) as individuals licensed to practice medicine, osteopathic medicine and surgery, or podiatric medicine and surgery (collectively, "physicians"), Chapter 2A of the Business Corporation Act – Professional Service Corporations (PC Act) and the Professional Limited Liability Company provisions of the Limited Liability Company Act (LLC Act), respectively, permit a PA to hold equity with physicians in the same professional corporation (PC) or professional limited liability company ("PLLC") formed to provide professional medical and surgical services.²⁴⁹ To the extent that one or more PAs organize a professional services corporation, a PC, or a PLLC with one or more physicians, the physicians who are parties to a practice agreement with such PAs must be shareholders or members of the PC or PLLC.²⁵⁰ In other words, a PA who holds equity in a PC or PLLC with physicians must have a practice agreement with a physician who also holds equity in the same PC or PLLC.

Advance Practice Registered Nurses

As a health professional licensed under the Code as an RN, one or more APRNs may become shareholders or members in a PC or a PLLC, respectively, formed to provide professional nursing services.²⁵¹ However, because RNs and APRNs provide a different professional service from other professionals licensed under the Code (e.g., physicians, PAs, physical therapists, occupational therapists), the PC Act and the PLLC Act do not permit RNs/APRNs to hold equity in the same PC or PLLC with these other licensed health professionals.²⁵² APRNs are not, however, limited to using a PC or PLLC when forming a legal entity to provide professional nursing services. Under the PC Act and the LLC Act, only "learned professionals" are required to use a PC or PLLC to provide their professional services in corporate form.²⁵³ An APRN does not fall within the definition of "learned professional,"²⁵⁴ so may choose to incorporate as a PC or PLLC, or as a business (profit) corporation or limited liability company (LLC).²⁵⁵ When preparing articles of incorporation for a PC or articles of organization for a PLLC an APRN should be careful to state the purpose of the entity is to provide professional nursing services within the legal scope of

practice of the APRN. LARA may reject articles with corporate purposes that suggest the entity will be providing professional medical services.

Conclusion

Public Acts 379 and 499 of 2016 have undoubtedly expanded the legal scope of practice of PAs and APRNs, respectively, in the state of Michigan. This expansion, however, is not without legal parameters designed to protect the integrity of the licensed health care professions and the safety of their patients. As licensed health care professionals, PAs and APRNs have a duty to understand and follow the legal parameters of their newly expanded scope of practice. By following these legal parameters, PAs and APRNs will protect themselves from professional disciplinary action against their own licenses and promote patient safety through appropriate collaboration with physicians.

Glossary of Abbreviations and Acronyms

AANP	American Academy of Nurse Practitioners; later to become American Association of Nurse Practitioners in 2013
AAPA	American Association of Physician Assistants, later to become American Academy of Physicians Assistants
ACA	Affordable Care Act
ACEN	Accreditation Commission for Education in Nursing
AMA	American Medical Association
APP	Advanced Practice Provider
APPs	Advanced Practice Providers
APRNs	Advanced Practice Registered Nurses
ARC-PA	Accreditation Review Commission on Education for the Physician Assistant
CAAHEP	Commission on Accreditation of Allied Health Education Programs
CAHEA	Committee on Allied Health Education and Accreditation
CCNE	Commission on Collegiate Nursing Education
CMS	Centers for Medicare and Medicaid Services
DEA	Drug Enforcement Administration
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LARA	Michigan Department of Licensing and Regulatory Affairs
MAPA	Michigan Academy of Physician Assistants
MDHHS	Michigan Department of Health and Human Services
MPHC	Michigan Public Health Code
NCLEX-RN	National Council Licensure Examination-RN
NCCPA	National Commission on Certification of Physician Assistants
NP	Nurse Practitioner
NPs	Nurse Practitioners
PA	Physician's Assistant; Physician Assistant
PA-C	Physician Assistant-Certified
PANCE	Physician Assistant National Certifying Exam
QPP	Quality Payment Program
RN	Registered Nurse

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- ²⁰⁷ MCL 333.17212(3).
- ²⁰⁸ LARA, *Nursing FAQs*, Question 21, p 6, <https://www.michigan.gov/documents/lara/Nursing_FAQs_updated_579848_7.pdf> (accessed June 14, 2018).
- ²⁰⁹ 21 C.F.R. § 1301.22(c).
- ²¹⁰ LARA, *Nursing FAQs*, Question 21, p 6, <https://www.michigan.gov/documents/lara/Nursing_FAQs_updated_579848_7.pdf> (accessed June 14, 2018).
- ²¹¹ Mich. Admin. Code R 338.2411.
- ²¹² Mich. Admin. Code R 338.2411(1).
- ²¹³ Mich. Admin. Code R 338.2411(2).
- ²¹⁴ Mich. Admin. Code R 338.2411(5).
- ²¹⁵ Mich. Admin. Code R 338.2411(3) and (4).
- ²¹⁶ Mich. Admin. Code R 338.2411(6).
- ²¹⁷ MCL 333.7333b.
- ²¹⁸ Mich. Admin. Code R 338.2411(7).
- ²¹⁹ MCL 333.17211a(1)(a), 333.17607(3), 333.17708(2), 333.17820(1), and 333.20201.
- ²²⁰ MCL 333.16215(1).
- ²²¹ Mich. Admin. Code R 338.2411.
- ²²² Michigan Medicaid Provider Manual, Practitioner Chapter, Section 22.1.
- ²²³ Michigan Medicaid Provider Manual, Practitioner Chapter, Section 23.2.B.
- ²²⁴ Michigan Medicaid Provider Manual, Practitioner Chapter, Section 23.3.
- ²²⁵ *Id.*
- ²²⁶ *Id.* The Medicaid Provider Manual does not address services provided by a CNS.
- ²²⁷ Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 15, Section 180.E.
- ²²⁸ Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 15, Sections 200.D and 210.D.
- ²²⁹ Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 15, Sections 200.D and 210.D.
- ²³⁰ Certification statement on Medicare Health Insurance Claim Form 1500, Medicare program instructions requiring that covered services must be within the PA's/APRN's legal scope of practice and provided under the supervision/collaboration required under state law are found at Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 15, Sections 180.C.1, 180.E, 190.B, 190.C, 200.B, 200.D, 210.B, 210.D.
- ²³¹ Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 15, Sections, 180.C, 190.B, 200.B and 210.B.
- ²³² MCL 333.16215.
- ²³³ Michigan Medicaid Provider Manual, Practitioner Chapter, Section 19.
- ²³⁴ MCL 333.17001(1)(i) and 333.17047(1).
- ²³⁵ Michigan Medicaid Provider Manual, Practitioner Chapter, Sections 22.2 and 22.7.
- ²³⁶ MCL 333.17211a(1)(a).
- ²³⁷ Michigan Department of Health and Human Services, Medical Services Administration, Proposed Policy Draft "Update to the Coverage of Physician Assistant Services," Proposed Issuance Date: September 1, 2018; Proposed Effective Date: October 1, 2018.
- ²³⁸ *Id.*
- ²³⁹ *Id.*
- ²⁴⁰ *Id.*
- ²⁴¹ *Id.*
- ²⁴² *The Record*, Blue Cross and Blue Shield of Michigan, (August, 2017 and January, 2018).
- ²⁴³ *The Record*, Blue Cross and Blue Shield of Michigan, (January, 2018).
- ²⁴⁴ *The Record*, Blue Cross and Blue Shield of Michigan, (August, 2017 and January, 2018).
- ²⁴⁵ *Id.*

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- ²⁴⁶ MCL 333.17211a(1)(a).
²⁴⁷ MCL 333.17211a(3).
²⁴⁸ *The Record*, Blue Cross and Blue Shield of Michigan (December, 2017).
²⁴⁹ MCL 450.1284(3) and 450.4904(4).
²⁵⁰ MCL 333.17048(3).
²⁵¹ MCL 450.1282(a), 450.1283(1), 450.4902(a), and 450.4903(1).
²⁵² MCL 450.1284(1), 450.4904(2).
²⁵³ MCL 450.1201(2) and (3), 450.1281(1), 450.4201, 450.4102(2)(t).
²⁵⁴ MCL 450.1109(1) and 450.4102(2)(t).
²⁵⁵ MCL 450.1201(3), 450.1281(1), and 450.4901(1).